ODSP Preparation Form

Health Status Report & Activities of Daily Living

Complete digitally or by hand — bring to your appointment

Patient Information

Full Name	Date of Birth	Appointment Date

Home Address	
Street	
City / Province / Postal Code	

Phone Number	Email Address	ODSP Member ID (9-digit)	Referral ID (12-digit)

Section 1 — Medical Conditions, Impairments & Restrictions

List ALL conditions that affect your health. For each: name the diagnosis, describe symptoms (impairments), and explain how they limit work, home, or community functioning (restrictions).

Condition 1	
Diagnosis / Condition Name	
Impairments (Symptoms)	
Restrictions / Limitations	
Duration / Onset	
Continuous or Episodic?	☐ Continuous ☐ Episodic / Recurrent
Prognosis	
Condition 2	
Diagnosis / Condition Name	
Impairments (Symptoms)	
Restrictions / Limitations	
Duration / Onset	
Continuous or Episodic?	☐ Continuous ☐ Episodic / Recurrent
Prognosis	

Condition 3	
Diagnosis / Condition Name	
Impairments (Symptoms)	
Restrictions / Limitations	
Duration / Onset	
Continuous or Episodic?	☐ Continuous ☐ Episodic / Recurrent
Prognosis	
Condition 4	
Diagnosis / Condition Name	
Impairments (Symptoms)	
Restrictions / Limitations	
Duration / Onset	
Continuous or Episodic?	☐ Continuous ☐ Episodic / Recurrent
Prognosis	

If you have more than 4 conditions, attach a separate sheet.

Section 2 — Current Medications

List all current medications with dose and frequency. Describe how well each works and any side effects that limit your functioning.

Medication Name	Dose / Frequency	Effectiveness	Side Effects Affecting Functioning

Other Treatments (Past & Current)

Include: physiotherapy, OT, counselling, specialist referrals, surgeries, hospital admissions, proposed future treatments.

Treatment / Provider	Dates	Status	Outcome / Notes
		☐ Past ☐ Current ☐ Proposed	
		☐ Past ☐ Current ☐ Proposed	
		☐ Past ☐ Current ☐ Proposed	
		☐ Past ☐ Current ☐ Proposed	
		☐ Past ☐ Current ☐ Proposed	

Intellectual & Emotional Wellness Scale (IEWS)

Who should complete this section?

Complete if you have any mental health conditions, substance use concerns, or neurocognitive/developmental conditions (ADHD, autism, learning disability, brain injury, dementia). Also complete if ANY of the symptoms below affect you — including when caused by a physical condition (e.g., poor sleep or concentration due to chronic pain).

Rating Scale: 0 = Not present | 1 = Mild (present, minor impact) | 2 = Moderate (noticeably affects daily functioning) | 3 = Severe / Marked (substantially impairs functioning)

Symptom / Feature	0	1	2	3	Notes / Observations
Amotivation Lack of motivation, inability to initiate or sustain tasks, low drive	☐	☐	☐	☐	
Anxiety Excessive worry, fear, panic attacks, avoidance behaviour	☐	☐	☐	☐	
Appetite Change Type: ☐ Increase ☐ Decrease	☐	☐	☐	☐	
Attention Deficit Difficulty sustaining attention, easily distracted, cannot focus on tasks	☐	☐	☐	☐	
Comprehension Deficit Difficulty understanding spoken or written information	☐	☐	☐	☐	
Concentration Deficit Cannot concentrate long enough to complete tasks, conversations, or reading	☐	☐	☐	☐	
Delusions False beliefs not shared by others; paranoia; unusual or fixed beliefs	☐	☐	☐	☐	
Depressive Mood Persistent sadness, hopelessness, tearfulness, loss of pleasure (anhedonia)	☐	☐	☐	☐	
Disinhibition Inappropriate behaviour, loss of social filter, acting without regard for consequences	☐	☐	☐	☐	
Disorientation Confusion about time, place, or person; becoming lost in familiar places	☐	☐	☐	☐	

Dissociative Symptoms Feeling detached from self or surroundings; gaps in memory; depersonalization	☐	☐	☐	☐	
Emotional Dysregulation Inability to manage or modulate emotional responses; extreme reactions	☐	☐	☐	☐	
Emotional Change Type: ☐ Increase (heightened reactivity) ☐ Decrease (blunted / flat affect)	☐	☐	☐	☐	
Euphoria or Elation Abnormally elevated or expansive mood; excessive happiness not consistent with circumstances	☐	☐	☐	☐	
Energy Change Type: ☐ Increase (hyperactivity / racing) ☐ Decrease (fatigue / anergia)	☐	☐	☐	☐	
Grandiosity Inflated self-esteem, exaggerated sense of importance, unrealistic beliefs about abilities	☐	☐	☐	☐	
Hallucination Hearing, seeing, smelling, or feeling things that others do not perceive	☐	☐	☐	☐	
Impulse Control Deficit Acting without thinking, inability to delay responses, risk-taking behaviour	☐	☐	☐	☐	
Insight Deficit Limited awareness of own illness, symptoms, or their impact on others	☐	☐	☐	☐	
Judgment Deficit Difficulty making safe, appropriate decisions; poor risk assessment	☐	☐	☐	☐	
Learning Deficit Difficulty acquiring new skills or information Specify area(s): _____	☐	☐	☐	☐	
Memory Deficit Type: ☐ Short-term ☐ Long-term ☐ Working memory	☐	☐	☐	☐	
Psychomotor Type: ☐ Agitation (restlessness, inability to sit still) ☐ Retardation (slowed movement, speech, thinking)	☐	☐	☐	☐	

Sleep Dysfunction Type: ☐ Difficulty sleeping (insomnia, non-restorative sleep) ☐ Excessive sleeping (hypersomnia)	☐	☐	☐	☐	
Speech Deficit Not due to language barrier Specify (e.g., dysarthria, word-finding, pressured, poverty of speech): _____	☐	☐	☐	☐	
Suicidality Type: ☐ Thoughts / Passive ideation ☐ Active ideation ☐ Plans ☐ Attempts (past or current)	☐	☐	☐	☐	
Thought Disorganization Disorganized or incoherent thinking, loosening of associations, tangential thought	☐	☐	☐	☐	
Withdrawal Social withdrawal, isolation, disengagement from activities and relationships	☐	☐	☐	☐	

Fluctuations in Severity

Describe how the severity of your symptoms varies over time — for example, triggers that worsen symptoms, frequency and duration of episodes, and impact of good vs. bad days on your ability to function:

Activities of Daily Living Index (ADLI)

Rate how your disability affects each activity on your WORST or most typical bad days. 0 = No limitation | 1 = Mild (minor help / extra time needed) | 2 = Moderate (need support or supervision) | 3 = Severe (cannot do it / someone else does it)

Personal Care & Physical Activities

#	Activity	0	1	2	3	Describe Limitation (if rated 1, 2 or 3)
1	**Bladder Control** *Accidents, incontinence, need reminders or protective products*	☐	☐	☐	☐	
2	**Bowel Control** *Accidents, need for management or protective products*	☐	☐	☐	☐	
3	**Bathing / Self-Cleaning** *Ability to shower or bathe safely and independently*	☐	☐	☐	☐	
4	**Grooming** *Hair, teeth, nails, shaving, facial hygiene*	☐	☐	☐	☐	
5	**Dressing** *Buttons, zippers, laces, overhead clothing*	☐	☐	☐	☐	
6	**Selecting Clothes** *Appropriate clothing for weather, occasion, or season*	☐	☐	☐	☐	
7	**Meal Preparation** *Planning, cooking safely, using kitchen appliances*	☐	☐	☐	☐	
8	**Eating** *Using utensils, cutting food, chewing, swallowing*	☐	☐	☐	☐	
9	**Shopping** *Making a list, navigating a store, paying, carrying items*	☐	☐	☐	☐	
10	**Housekeeping** *Cleaning, vacuuming, dishes, tidying living space*	☐	☐	☐	☐	
11	**Laundry** *Washing, drying, folding, and putting away clothes*	☐	☐	☐	☐	

12	**Physical Activity** *Sustained physical activity appropriate for age*	☐	☐	☐	☐	
13	**Mobility / Getting Around** *Walking distances, navigating indoors and outdoors*	☐	☐	☐	☐	

Movement, Access & Community Activities

#	Activity	0	1	2	3	Describe Limitation (if rated 1, 2 or 3)
14	**Sitting** *Sustained sitting without pain, discomfort, or dizziness*	☐	☐	☐	☐	
15	**Standing** *Duration, stability, pain or fatigue while standing*	☐	☐	☐	☐	
16	**Stair Climbing** *Safety, stamina, need for railing or assistance*	☐	☐	☐	☐	
17	**Transferring** *Moving between bed, wheelchair, toilet, chair*	☐	☐	☐	☐	
18	**Transportation** *Using public transit or driving independently*	☐	☐	☐	☐	
19	**Medical Appointments** *Remembering, attending, communicating with health providers*	☐	☐	☐	☐	
20	**Managing Finances** *Paying bills, budgeting, banking, avoiding financial errors*	☐	☐	☐	☐	
21	**Managing Medications** *Right dose, right time, without reminders*	☐	☐	☐	☐	
22	**Communication** *Phone calls, texts, emails — written and verbal*	☐	☐	☐	☐	
23	**Cognitive Activities** *Reading, writing, following instructions, filling out forms*	☐	☐	☐	☐	

24	**Personal Safety** *Awareness of risks, judgment, avoiding dangerous situations*	☐	☐	☐	☐	
25	**Social Interactions** *Getting along with others, managing conflict, maintaining relationships*	☐	☐	☐	☐	
26	**Hobbies / Leisure** *Participating in enjoyable activities and interests*	☐	☐	☐	☐	

Services or Supports Needed

Indicate which services or supports you currently need or are likely to need as a result of your disability:

Service / Support Type	Needed?	Details / Frequency
Personal care / attendant care	☐ Yes ☐ No	
Home help / homemaking	☐ Yes ☐ No	
Meal preparation assistance	☐ Yes ☐ No	
Transportation assistance	☐ Yes ☐ No	
Behaviour management support	☐ Yes ☐ No	
Life skills training program	☐ Yes ☐ No	
Supported employment / vocational rehabilitation	☐ Yes ☐ No	
Assistive devices (mobility aids, hearing, vision, etc.)	☐ Yes ☐ No	
Specialized mental health services	☐ Yes ☐ No	
Addiction treatment services	☐ Yes ☐ No	
Other (specify below)	☐ Yes ☐ No	

Additional Comments

Any other information about your disability and how it affects your daily life:

⚠ Submission Reminder

Please Print/E-mail the following documents:

☐ Consent to Release Personal Information (filled and signed **on original document**)

☐ Patient Self Report (signed **on original document**)

☐ This form (emailed or printed)

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